Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 2—Membership and Benefits

PROPOSED AMENDMENT

16 CSR 50-2.120 Benefits Upon Participant's Death. The board is adding a new section (6).

PURPOSE: This amendment adds a new section to amend the death benefit to reflect compliance with federal law.

(6) In the case of a participant who dies while performing qualified military service (as defined in section 414(u) of the Code), the survivors of the participant are entitled to any additional benefits (other than benefit accruals relating to the period of qualified military service) provided under the plan had the participant resumed and then terminated employment on account of death. The foregoing shall be effective with respect to deaths occurring on or after January 1, 2007. Notwithstanding anything herein to the contrary, the plan shall be administered to comply with the Heroes Earnings Assistance and Tax Relief Act of 2008, to the extent required therein.

AUTHORITY: section 50.1032, RSMo 2000. Original rule filed Sept. 29, 2000, effective March 30, 2001. Amended: Filed Nov. 10, 2005, effective May 30, 2006. Amended: Filed Sept. 5, 2007, effective March 30, 2008. Amended: Filed Sept. 8, 2008.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the County Employees' Retirement Fund, 2121 Schotthill Woods Drive, Jefferson City, MO 65101. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 10—County Employees' Defined Contribution Plan

PROPOSED AMENDMENT

16 CSR 50-10.050 Distribution of Accounts. The board is amending subsection (2)(A).

PURPOSE: This amendment provides that the amount available for a hardship distribution will be limited to the lesser of the amount sufficient to meet the need and the vested amounts in a participant's account.

(2) Distribution Due to Hardship. A Participant may request a distribution due to Hardship by submitting a request to the Board (or its designee) in such form as may be permitted by the Board (or its designee). The Board (or its designee) shall have the authority to require such evidence as it deems necessary to determine if a distribution is warranted. If an application for a distribution due to a Hardship is approved, the distribution is limited to the lesser of—

(A) An amount sufficient to meet the need*[, less the value of the Participant's account in the 457 Plan]*; or

*AUTHORITY: section[s] 50.1250, RSMo Supp. [2006] **2007** and **section** 50.1260, RSMo 2000. Original rule filed May 9, 2000, effective Jan. 30, 2001. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Sept. 8, 2008.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the County Employees' Retirement Fund, 2121 Schotthill Woods Drive, Jefferson City, MO 65101. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 100—Insurer Conduct
Chapter 1—Improper or Unfair Claims Settlement Practices

PROPOSED RULE

20 CSR 100-1.060 Standards for Prompt, Fair, and Equitable Settlements under Health Benefit Plans

PURPOSE: This rule effectuates or aids in the interpretation of section 375.1007, RSMo 2000, and sections 376.383 and 376.384, RSMo Supp. 2007.

(1) Scope. This rule applies to all claims submitted by a claimant to a health carrier or its third-party contractor after September 1, 2009, and that health benefit plan is either a fully-insured group health benefit plan where the provider submits claims as a participating provider or is an individual health benefit plan.

(2) Definitions. As used in sections 376.383 and 376.384, RSMo, and in the regulations promulgated pursuant thereto—

(A) "Acknowledgment of the date of receipt" shall mean a written notice, whether made in electronic or nonelectronic format, to the claimant by the health carrier or its third-party contractor that it received a claim and setting forth the date on which the claim was received;

(B) "Claim" shall mean a written request or demand by a claimant for the payment of health care services provided, whether made in an electronic or nonelectronic format;

(C) "Confirmation of receipt" shall mean a written notice, made in electronic or nonelectronic format, to the health care provider by the health carrier or its third-party contractor that it received an electronically-filed claim. A confirmation of receipt may also constitute an acknowledgement of the date of receipt if it meets the requirements of subsection (A) of this section;

(D) "Date of claim payment" shall mean the date the health carrier or its third-party contractor mails or sends the payment as indicated by the date of—

1. The postmark, if a claim payment is delivered by the U.S. Postal Service;

2. The electronic transmission, if the payment is made electronically;

3. The delivery of the claim payment by a courier; or

4. The receipt by the claimant, if the claim payment is made other than as provided in paragraphs (2)(D)1. through (2)(D)3.,

above;

(E) "Date of denial" shall mean the date when the health carrier or its third-party contractor mails or electronically sends a denial;

(F) "Date of receipt" shall mean the date upon which the health carrier or its third-party contractor first receives a claim or other information relevant and pertinent to the claim, indicated by the date of—

1. The postmark, if a claim payment is delivered by the U.S. Postal Service;

2. The electronic transmission, if the payment is made electronically; or

3. The date stamped by the health carrier or its third-party contractor, if the claim is delivered in a manner other than those described above;

(G) "Deny" or "denial" shall mean the health carrier or its third-party contractor mails or sends an electronic or written notice to the claimant refusing to reimburse all or part of the claim, which includes each reason for the denial;

(H) "Health benefit plan" shall mean health benefit plan as defined in section 376.1350, RSMo;

(I) "Notification of claim" shall mean any notification to a carrier or its third-party contractor, by a claimant, which reasonably apprises the health carrier of the facts pertinent to a claim;

(J) "Pay" or "payment" shall mean the health carrier or its third-party contractor mails or sends electronic or written notice including remuneration to the claimant that reimburses all or part of the claim;

(K) "Processing days" shall mean the number of days the health carrier or its third-party contractor has the claim in its possession. Processing days shall not include days in which the health carrier is waiting for a response to a reasonable request for additional necessary information;

(L) "Reason for denial" shall mean a contract provision or provisions upon which a health carrier is basing its denial of a claim or any portion of a claim;

(M) "Request for additional information" shall mean when the health carrier or its third-party contractor requests, in writing, whether made in electronic or nonelectronic format, additional necessary information from the claimant to determine if all or part of the claim will be reimbursed. Such a request must meet the following requirements:

1. It shall be specific to the claim or the claim's related episode of care;

2. It shall describe with specificity the clinical and other information to be included in the response;

3. It shall be relevant and necessary for the resolution of the claim; and

4. It shall be for information that is contained in or in the process of being incorporated into the patient's medical or billing record maintained by the health care provider;

(N) "Suspends the claim" shall mean when a health carrier or its third-party contractor mails or electronically sends a written notice to the claimant specifying the reason the claim is not yet paid or denied, including, but not limited to, grounds as listed in the contract between the claimant and the health carrier;

(O) "Suspension date" shall mean the date the health carrier or its third-party contractor mails or sends electronic written notice that the claim is suspended;

(P) "Third-party contractor" shall mean an entity or person directly or indirectly contracted with the health carrier to receive or process claims for reimbursement of health care services; and

(Q) "Working days" shall mean the number of consecutive days not counting weekends or federal holidays.

(3) Communications Between Entities Subject to This Rule.

(A) An entity subject to this rule may deliver written communication as follows:

1. By U.S. mail, first-class delivery; by U.S. mail, return receipt requested; or by overnight mail, and maintain a copy of the receipt or signature card acknowledging receipt of delivery;

2. Electronically and maintain proof of the electronically submitted communication;

3. If the entity accepts facsimile transmissions for the type of communication being sent, then fax the communication and maintain proof of the facsimile transmission; or

4. Hand delivery of the communication and maintain a copy of the signed receipt acknowledging the hand delivery.

(B) Communication is presumed to be received as follows:

1. On the date shown by a date stamp showing the actual date received, if the sender used U.S. mail, first-class delivery;

2. On the date the delivery receipt is signed, if the sender used an overnight delivery service or the U.S. mail, return receipt requested, or if the sender hand delivered the communication; or

3. If the communication was received electronically, an electronic verification or confirmation of receipt must be issued to the sender within twenty-four (24) hours of the receipt of the communication.

(4) Standards for Prompt, Fair, and Equitable Settlements under Health Benefit Plans.

(A) Every health carrier or third-party contractor, upon receiving notification of a claim from a claimant, shall, within ten (10) working days—

1. Pay the total amount of the claim in accordance with the contract between the health carrier and the health care provider or the health carrier and the insured or enrollee; or

2. Send an acknowledgement of the date of receipt and do one (1) or more of the following:

A. Send written notice of status of the claim, whether made in electronic or nonelectronic format, with request for specific additional pertinent claim information and from whom it is requested, such as the claimant, the patient, or another health care provider;

B. Pay the portion of the claim for which the health carrier acknowledges liability in accordance with the contract between the health carrier and the health care provider or the health carrier and the insured or enrollee, suspend the remainder of the claim, and request specific additional pertinent claim information;

C. Pay the portion of the claim for which the health carrier acknowledges liability in accordance with the contract between the health carrier and the health care provider or the health carrier and the insured or enrollee, and deny a portion of the claim and specify each reason for the denial; or

D. Deny the claim in its entirety and specify each reason for such denial.

(B) If notice of the claim was received as an electronically filed claim, the health carrier shall issue confirmation of receipt of the claim within one (1) working day of its receipt to the claimant that submitted the claim electronically.

(C) If additional information is requested, an appropriate reply shall be made within fifteen (15) processing days of receiving any additional claim information from whom the information was requested. An appropriate reply shall mean payment of all or the undisputed portion of claim, denial of the claim, suspension of the claim, or final request for additional pertinent and relevant information.

(D) All denials, suspensions, or requests for additional information shall be communicated in writing to the claimant and shall include specific reasons why the action was taken or why the information is needed.

(5) Health carriers must conduct a reasonable investigation before denying or suspending a claim in whole or in part. Health carriers shall not suspend or deny claims for the lack of information until it has requested the pertinent additional information on two (2) separate occasions.

(A) Claims.

1. If a claim or portion of a claim remains unpaid after forty-five

(45) days after notification of the claim, interest shall accrue beginning on the forty-sixth day after the date of receipt of the claim at a rate equal to one percent (1%) per month of the unpaid balance of the claim until the claim is paid. The interest shall be payable by the health carrier to the health care provider, individual insured, or other entity submitting the claim. If the health carrier denies or suspends a claim that is subsequently determined to be the liability of the health carrier, the health carrier will be responsible for the interest from the forty-sixth day of the original date of notification of the claim until the claim is actually paid.

2. Any improperly denied claims that are subsequently determined to be payable shall have interest calculated from the forty-sixth day after the date of receipt of the claim.

3. The health carrier may wait until the claimant's aggregate interest payments reach five dollars ($5) before making interest payment to the claimant.

(B) Duties of the Health Carrier.

1. When a health carrier pays or denies a claim, it shall explain in sufficient detail how each item or service was reimbursed. Specifically, if the health carrier has a contract rate with the health care provider, the health carrier shall indicate which items or services are included in the reimbursement and which items are not included in the reimbursement.

2. Pursuant to the requirements of 20 CSR 100-8.040, health carriers shall maintain and legibly date stamp all documentary material related to the pertinent events of a claim. Pertinent events shall include, but not be limited to, the date of the notification of claim, date of payment, date of denial, date of suspension, reason for denial or suspension, amount paid, amount denied, amount suspended, date additional information is requested, the nature of the specific additional information requested, and the date such additional information was received.

3. After notification of a claim, if any information on the claim that affects the amount of benefits payable is changed or omitted in the processing of the claim, including any electronic edits, the health carrier or its third-party contractor shall notify the claimant of the modification in writing with specificity.

4. Any contractual agreement between the health carrier and any of its third-party contractors that receives or processes claims, obtains the service of a health care provider to provide health care services, or issues verifications or pre-authorizations may not be construed to limit the health carrier's authority or responsibility to comply with all applicable statutory and regulatory requirements of this rule or of sections 376.383 and 376.384, RSMo.

5. Contracts between health care providers, health carriers, and their respective third-party contractors shall not extend the statutory or regulatory time frames set forth in this rule or in sections 376.383 and 376.384, RSMo.

(C) Complaints Against Health Carriers. Every complaint made by a health care provider to the director shall include: the health care provider's name, address, and daytime phone number; the health carrier's name; the date of service and date the claim was filed with the health carrier; all relevant correspondence between the health care provider and the health carrier, including requests from the health carrier for additional information; a copy of the confirmation of receipt or acknowledgment of the date of receipt of the claim from the health carrier or its third-party contractor, if available; and additional information which the health care provider believes would be of assistance in the department's review.

AUTHORITY: sections 375.045 and 376.1007, RSMo 2000 and sections 376.383 and 376.384, RSMo Supp. 2007. Original rule filed Sept. 5, 2008.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: A public hearing will be held on this proposed rule at 10:00 a.m. on November 18, 2008. The public hearing will be held at the Harry S Truman State Office Building, Room 530, 301 West High Street, Jefferson City, Missouri. Opportunities to be heard at the hearing shall be afforded to any interested person. Interested persons, whether or not heard, may submit a written statement in support of or in opposition to the proposed rule, until 5:00 p.m. on November 25, 2008. Written statements shall be sent to Tamara Kopp, Department of Insurance, Financial Institutions and Professional Registration, PO Box 690, Jefferson City, MO 65102.

SPECIAL NEEDS: If you have any special needs addressed by the Americans With Disabilities Act, please notify us at (573) 751-2619 at least five (5) working days prior to the hearing.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 100—Insurer Conduct
Chapter 1—Improper or Unfair Claims Settlement Practices

PROPOSED RULE

20 CSR 100-1.070 Identification Cards Issued by Health Carriers

PURPOSE: This rule sets forth the requirements for an identification card issued to insureds or enrollees by health carriers offering health benefit plans.

(1) Applicability. This rule applies to all health carriers offering or providing a plan of health insurance, health benefits, or health services to individuals and groups, or administering health benefit plans on behalf of self-insured employer groups.

(2) Definitions. As used in this section—

(A) "Health benefit plan" shall mean health benefit plan as defined in section 376.1350(18), RSMo; and

(B) "Health carrier" shall mean health carrier as defined in section 376.1350(22), RSMo.

(3) Identification Cards.

(A) An identification card or similar document issued to insureds or enrollees shall include the following information:

1. The name of the enrollee or insured;

2. The first date on which the enrollee or insured became eligible for benefits under the plan or a toll-free number that a health care provider may use to obtain such information; and

3. Indicate that the health benefit plan offered by the health carrier is regulated by the Department of Insurance, Financial Institutions and Professional Regulation by placing "DOI" on the front.

(B) Nothing shall prohibit the issuer of a health benefit plan from using an identification card containing a magnetic strip or other technological component enabling the electronic transmission of information, provided that the information required in this section is printed on the card.

(C) The requirements of this section shall apply to all health benefit plans issued or renewed twelve (12) months after this rule becomes effective.